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EDITORIALS

PUBLIC HEALTH: THEN AND NOW

IN little over a year the American Public Health Association will celebrate its centennial. Partly in preparation for this event we are inaugurating a new department in the Journal to be called "Public Health: Then and Now." Under this rubric we shall present from time to time, on a monthly basis if possible, articles and documents indicative of the issues, concerns, and contributions of public health in general and of the Association in particular over the past hundred years, and wherever possible attention will be given to their continuing relevance. The very nature of public health requires action to deal with the immediate, to become engaged with current problems. Yet to deal with the present, to understand today, it is also necessary to see the immediate in perspective, to look at the present in the context of the past and to endeavor to understand their relations. Many problems of current concern have their roots in the past; they are a manifestation of long-term trends and should, therefore, be understood from both a long-term and a short-term point of view. In this issue we present a statement by Lee K. Frankel, president of the Association in 1919 on

the new program of activity which had then been formulated. At a time when our Association is again charting a new course, it is indeed a matter of interest to see to what extent our plans and purposes and those of our predecessors over fifty years ago diverge. Future issues will offer material on local health centers, health insurance, narcotic addiction, problems of urban growth, the defunct section on Sociology and other matters.

The Need for Patient Education

EDUCATION of the public concerning disease prevention through activities fostering such programs as immunizations, nutrition, sanitation, and prenatal care have been considered a routine function of public health agencies for years. Indeed, health education and public health educators have been an accepted part of the essential services of such agencies. The same cannot be said, however, for general hospitals and long-term care facilities. While some few health facilities do provide a carefully planned health education program, in most instances teaching experiences are the result of coordinated efforts of individuals untrained in current educational princi-

ples, methodology, or educational research. In short, patient and family education, if provided, is usually on an incidental, accidental, ad hoc basis.

In the early 1950s, interest in patient education as an organized part of a total care plan was sparked by the interest of a few health educators on the staff of the National Tuberculosis Association. With the advent of the Chronic Disease Program of the Public Health Service, and the availability of demonstration funds, patient education projects relating to diabetes and rheumatic fever began to appear.

In the early 60s, voluntary agencies and the Public Health Service funded several successfully planned patient and family education projects concerning congestive heart failure, stroke, cancer, and, more recently, renal dialysis. Hospitals in California, New Jersey, Connecticut, Massachusetts, and New York also became involved in various projects and programs. The American Hospital Association sponsored two invitational conferences on patient education and has conducted instructional sessions at annual meetings. Pharmacists, dietitians, and other professions in the medical care field recently have begun to publish journal articles related to "their role and responsibility" for patient education. While each discipline concentrates on its particular professional group, one single common thread emerges *that the patient and family need to know*.

Some may feel that the patient's need to know is based on a moral or ethical principle: that he has a responsibility to know. Others simply expect better cooperation or adherence to a prescribed regimen because of instruction given. However, some recognize the need for an educational process through participation and involvement in order to bring about the proper decisions which the patient must face many times each day, e.g., to eat an apple or a candy bar, to

walk instead of ride, to purchase food and not medicine, to spend carfare to visit the clinic or physician rather than go to a movie. The patient who is readmitted or whose recovery at home is lengthened because of a failure to take medications correctly, to adhere to a prescribed regimen, or to follow a prepared exercise program must be considered as an educational failure and inadequately treated. Data available from several projects indicate that patients who are adequately informed and included in the educational process related to their own care and treatment have fewer hospital readmissions, adhere better to their diets, take their medications essentially without error; and, in general, follow the orders of their physician more closely. While no hard data are available, it appears there may be an additional benefit in terms of a money savings through a better and more efficient utilization of staff time through techniques such as group teaching.

The Health Education Section of the American Public Health Association, because of its concern that health care facility patients were not being provided information and education necessary to participate in their own health care, established a Committee on Educational Tasks in Chronic Illness in 1968.

Membership included representatives from a number of disciplines and from various sections of the country. The purpose of the committee was to study the problem and submit recommendations related to the educational components in caring for the chronically ill after the acute state of the illness.

The committee accepted seven basic premises as the basis for its work:

1. Children and young adults as well as older people suffer with chronic illness.
2. Patient education is an integral part of patient care.

3. Target groups to be considered in educational programming include:

- a. the patients and their families;
- b. staff members (at all levels) in their health care setting; and
- c. appropriate groups in the community.

4. The team approach, with the physician serving as the team leader and coordinator, offers the most effective approach to patient education.

5. Since various disciplines (e.g., occupational therapy, physical therapy, social service) may have different educational goals, the patient education program must be carefully reviewed and coordinated.

6. Consideration should be given to an "educational prescription" that would be available in written form and would accompany the patient as he moved from one facility to another.

7. All those involved in caring for the chronically ill have need for inservice and continuing education.

As a result of the Committee's work, a document entitled, "A Model For Planning Patient Education—An Essential Component of Health Care" has been published. The model is a mechanism for defining the educational processes neces-

sary for patient and family education and may be adapted for any illness regardless of its etiology or chronicity. It includes a basic five-step plan which can be used by physicians, nurses, social workers, health educators, and others responsible for planning and organizing education programs for patients and their families.

While standards for patient education have not yet evolved, a program which applies the concepts and guidelines espoused in the model should provide for a sound educational program that would benefit not only the patient and his family, but the health-care facility and the health profession. Additionally, a planned program utilizing these principles could serve as a basis for reimbursement either from the patient or a third party payer.

We highly recommend that all those engaged in health care obtain a copy of the report and consider its implementation. Copies are available from: Mr. Clarence E. Pearson, Director for Administration and Planning, Health and Welfare Division, Metropolitan Life, One Madison Avenue, New York, N.Y. 10010.

The Journal is indebted to Miss Joan M. Wolle, Division of Educational Services, State Dept. of Health and Mental Hygiene, 301 West Preston Street, Baltimore, Md. 21201.

LETTERS TO THE EDITOR

TO THE EDITOR:

A Reply to Dr. Frelick

In the article on "Popular Delusions," I did not include supporting data for I was addressing a conference of knowledgeable persons familiar with the vast literature on the subject. As a sample, I enclose copies of recorded observations

on over 7,000,000 insured federal employees and dependents.

One of the most comprehensive reviews was published recently in the Harvard Law Review, Vol. 84, No. 4, February, 1971; entitled "The Role of Prepaid Group Practice in Relieving the Medical Care Crisis." It has been reprinted as a monograph which can be